Department of Employee Trust Funds

INCOME CONTINUATION INSURANCE (ICI)
EMPLOYER STATEMENT

Wis. Stat. § 40.61 and 40.62

Employee Name
Social Security Number
Employer Identification Number

INSTRUCTIONS TO EMPLOYER:

The employee named below is applying for an ICI benefit. Please follow the detailed instructions on the back of this form and return it to ETF promptly. Benefits cannot be computed until this form is received and processed.

Occupation (Title) ☐ Seasonal/Academic Yr ☐ LTE ☐ Permanent ☐ Project ☐ Per Diem	Last Day Worked *(MM/DD/CCYY)*	Last Day Paid *(MM/DD/CCYY)*

Salary (Locals: monthly salary only) ☐ Biweekly ☐ Full Time ☐ Monthly ☐ Part Time $ _____ Part Time Percent _____%	Has claim been filed for Worker's Comp? ☐ Yes ☐ No ☐ Denied ☐ Pending	Worker's Comp. Effective Date _____ Paid Thru _____	Weekly Worker's Comp Amount $_____

(State Only) Total Sick Leave Shown to hundredths of an hour–2 Decimal Places Accumulated Hrs _____ Earned Hours _____ Total Hours _____	(State Only) Date Sick Leave is Exhausted *(MM/DD/CCYY)*	Premium Category/Elimination Period			
		Year _____	Year _____	Year _____	Current Year

(UW-Faculty Only) Elimination Period- Calendar Days 30 90 125 180	(Locals Only) Elimination Period-Calendar Days 30 60 90 120 180	Premiums are Paid Through *(MM/DD/CCYY)*

(Locals Only) Percentage of Premium Paid by Employer in Prior Years:			
20_____ %	20_____ %	20_____ %	Current Year %

(State Only) Claimant Has Elected To:

☐ Use a Max. of 130 Days of Sick Leave   ☐ Bank All Sick Leave After:_____(MM/DD/CCYY)

Employer *(Circle: State or Local)*   Division *(State)*   Central Payroll Code Number *(State)*

I understand Wis. Stat. § 943.395 provides penalties for knowingly making false or fraudulent claims on this form and hereby certify that, to the best of my knowledge and belief, the above information is true and correct.

Date *(MM/DD/CCYY)*	Authorized Employer Signature

Employer contact e-mail address:	Employer Telephone No.

Date Sent to Employer:	Sent by:	Telephone Number:

ET-5351 (REV 07/2004)   **Mail to: ETF, PO BOX 7931, MADISON 53707-7931**
FAX: 608/267-4549

Employer Instructions

1. Complete and return this form as quickly as possible to: **ETF, PO BOX 7931, MADISON WI 53707-7931** or fax to ETF at 608/267-4549. No ICI benefits are payable to your employee until the completed form is received and processed.

2. For State or Local employees, report the last day paid for any vacation, holiday or compensatory time paid after the elimination period. For Local employees only, report last day paid for any sick leave paid.

3. Report salary as follows:

   - For **most State employees**, benefits are based on the basic gross salary, excluding overtime, paid during the last complete payroll period prior to the date disability begins. Earnings include permanent add-on pay awarded to an employee who holds certain educational degrees, certifications, licenses or credentials.

   - For **State LTE's (including per diem employees), project, seasonal or academic year employees** who worked the entire previous calendar year, use the total WRS reported earnings paid to the employee during the calendar year prior to the date disability began, rounded to the next higher thousand and divided by 12 for the monthly salary and then divided by 2.143 to determine the biweekly salary. If the employee did not receive earnings for the entire previous calendar year, or resumed state service after an interruption extending 3 consecutive months or more, report the current year's projected salary used to adjust premiums on February 1.

   - For **Local employees** who worked the entire previous calendar year, use the total earnings paid to the employee during the previous calendar year rounded to the next higher thousand and divided by 12 for the monthly salary. If the local employee did not receive earnings for the entire previous calendar year, or resumed covered service after an interruption extending 3 consecutive months or more, report the current year's projected salary used to adjust premiums on March 1.

4. For **State** employees, report the accumulated sick leave hours as of the employee's last day worked, plus any additional sick leave earned while continuing in pay status. Report sick leave in hours and hundredths of hours (2 decimal places), **not minutes**.

5. For most **State** employees who work a standard Monday – Friday work week, sick leave is not utilized on paid legal holidays and thus extends the date sick leave is exhausted.

6. For **State** employees, an ICI claimant who has applied for a Wisconsin Retirement System disability, Long Term Disability Insurance (LTDI) benefit, or duty disability benefit may convert (bank) sick leave to pay for health insurance premiums and begin ICI benefits at an earlier date. Determine, with the employee, the date through which sick leave is to be used. If the permanent disability is not approved, the date through which sick leave was used will have to be adjusted. Attach written documentation to this form which verifies the employee's decision to bank sick leave after a specified date.

7. Continue to collect premiums, for eligible employees, until you receive written notice of approval of the claim. Note that no premiums can be accepted after employment is terminated.

8. Under "Premium Category," fill in the premium category or selected elimination period for the year in which the disability began (current year) as well as the previous three calendar years.

9. After completion, please make a copy of this form for your records for future reference.

10. Please include your e-mail address.